Canadian Centre for Occupational Health and Safety

Centre canadien d'hygiène et de sécurité au travail

OCCUPATIONAL HEALTH AND SAFETY PROFESSIONALS A CHANGING ROLE?

A Workshop

P88 - 27E

OCCUPATIONAL HEALTH AND SAFETY PROFESSIONALS
A CHANGING ROLE?

A Workshop

Hamilton, Ontario
December 1 and 2, 1988

Canadian Centre for Occupational Health and Safety

CCOHS/CCHST

90-01082/

OCCUPATIONAL HEALTH AND SAFETY PROFESSIONALS
A CHANGING ROLE?

A WORKSHOP

CCOHS NUMBER P88-27E

ISBN O-660-13093-9

DSS CATALOGUE NUMBER CC273-2/88-27E

This publication is available in both official languages.
Cette publication est disponible dans les deux langues officielles.

Each document produced by CCOHS undergoes several stages of review. As a part of this review, representatives from each of government, employers, and labour are requested to comment on draft copies of CCOHS documents for technical accuracy and usability.

Although every effort is made to ensure accuracy and completeness of the information, it is understood that CCOHS makes no warranty as to the accuracy or completeness of such information and assumes no liability for any damages or loss suffered as a result of any inaccuracy or incompleteness therein.

In the interests of the widest possible dissemination of occupational health and safety information, CCOHS invites users to copy and distribute its publications. CCOHS asks that users report the number of copies so distributed - please notify the Inquiries Service. Users may wish to contact CCOHS to request paper or electronic master copies for reproduction.

Where excerpts only are copied, appropriate written acknowledgment of CCOHS is requested and appreciated.

Published 1989

Additional copies available upon request.

---

250 Main Street East
Hamilton, Ontario
L8N 1H6
(416) 572-2981
Telex 061-8532
Fax (416) 572-2206

CCOHS/CCHST

Canadian Centre
for Occupational Health and Safety
A Workshop

OCCUPATIONAL HEALTH & SAFETY PROFESSIONALS - A CHANGING ROLE?

Thursday, December 1 and Friday, December 2, 1988
Hamilton Convention Centre, Hamilton, Ontario

Thursday, December 1, 1988

8:15 am — REGISTRATION AND COFFEE - Albion BC Foyer

9:00 am — Welcome and Introduction to the Workshop - Albion BC

9:15 am — **Panel Discussion--Existing models of health services**

Labour Clinic
Jill Marzetti, Coordinator
Health & Safety Clinics
Ontario Federation of Labour

Employer Service Physician
Tony Hammer, Medical Director
Polysar Limited

Département de Santé Communautaire, Quebec
(Community Health Services)
Michel Guillemette, Vice President
Corporate Medical Affairs
Canadian Pacific Papers

Free-Lance Service
Jack Richman, Managing Director
The Industrial Doctor Medical Walk-in Clinic Inc

Occupational Health Nurse
Judy Pope, President
Ontario Occupational Health Nurses Association

Employer Hygiene and Safety
Jan Logan, Director
Occupational Hygiene & Safety
Northern Telecom

Questions and Discussion

11:00 am	COFFEE - Albion BC Foyer
11:15 am	**Workshop #1 - Discuss professionals and their role**
	(a) How you define an occupational safety and health professional. (b) The traditional role of OS&H professionals. (c) The developing role. (d) The issues pushing for change.
12:00 noon	LUNCH - Webster A & Lounge
1:15 pm	**Workshop #2 - Discuss the changes in occupational hygiene and safety services and activities**
	(a) How legislation is driving the change in roles. (b) Advantages and disadvantages. (c) Where OS&H services fit into the health care system. (d) Whether OS&H services can be integrated into the health care system.
2:00 pm	**Plenary Session - Albion BC**
	Group Reports -- Agreements and Disagreements A Way Forward
3:00 pm	COFFEE - Albion BC Foyer
3:15 pm	**Workshop #3 - Discuss anxieties and other problems**
	(a) Confidentiality and sensitivity. (b) Training/accreditation of professionals. (c) Biological monitoring and medical surveillance.
4:00 pm	**Workshop #4 - Discuss relationships**
	(a) Employer/professional Employee/professional Professional/professional Health & safety committee/professional Health/safety (b) What relationships need to be improved? Can they be improved? How?
5:30 pm	CASH BAR - Lounge
6:00 pm	DINNER - Webster AB & Lounge

Friday, December 2, 1988

8:45 am	COFFEE - Albion BC Foyer
9:00 am	**Workshop #5 - Homogeneous Groups**
10:15 am	COFFEE - Albion BC Foyer
10:30 am	**Plenary Session** - Albion BC **A Changing Role? - A Model and Procedures** Reports and Recommendations from Labour, Employers and Professionals
12:00 noon	CLOSE OF WORKSHOP

SUMMARY

The workshop was held in Hamilton on December 1 and 2. It was highly successful. Some 45 participants represented labour, industry and most occupational health and safety professions. Several participants congratulated the Centre for breaking down barriers among the various interest groups in occupational health and safety in Canada.

The opening panel made presentations on various occupational health and safety delivery systems. On the panel were: Jill Marzetti, Coordinator, Health and Safety Clinics, Ontario Federation of Labour; Tony Hammer, Medical Director, Polysar Limited; Jack Richman, Managing Director, The Industrial Doctor Medical Walk-in Clinic Inc; Judith Pope, President, Ontario Occupational Health Nurses Association; and Jan Logan, Director, Occupational Hygiene and Safety, Northern Telecom.

This was followed by mixed and homogeneous group discussion. The discussion centred on defining professionals and their role; changes in occupational hygiene and safety services and activities; anxieties and other problems; and relationships.

The consensus was that the role is moving from merely being well (as opposed to sick) to well-being. There will have to be much more cooperation with employers and workers, and openness in sharing information. Participants grappled with the difficult topic of definition of occupational health and safety professionals. In the end the definition by the working group of professionals as "a person who has advanced education, regularly upgraded; uses intellectual skills; belongs to a self-governing organization that hands out accreditation; and observes its code of ethics" was agreed by labour and management.

There was strong labour opposition to medical monitoring, but agreement that if it were practised, it should be within very clear guidelines.

Several recommendations were made to the Centre. Although labour had reported that it wanted professionals as a resource to, not as a part of, joint health and safety committees, it did not oppose the recommendation by the professionals that, on behalf of the workshop participants, the Centre request governments to legislate a role for professionals on joint health and safety committees.

The workshop also recommended that training and education in occupational health and safety be introduced in high schools; and that CCOHS have the role of coordinating occupational health and safety information across Canada.

Several participants congratulated the Centre for "breaking down barriers" among conflicting interests in occupational health and safety in Canada.

INTRODUCTION

Lillian Vine

I am delighted to see you here this morning. I am Lillian Vine, Manager of Committees and Workshops at the Canadian Centre for Occupational Health and Safety. I bring you warm greetings and wishes for a successful workshop from the President and Chief Executive Officer of CCOHS, Gordon Atherley, who is in Bologna, and from the Chairman of our Council of Governors, Martin O'Connell.

Our Council of Governors decided 2-1/2 years ago that CCOHS should facilitate workshops as a way of bringing people together to discuss important and sometimes difficult occupational health and safety issues and to uncover common ground. This extended and added to our information work the opinions of the stakeholders. Out of your discussions will come a proceedings; we transcribe the plenary sessions; we edit them and ask the workgroup chairmen and speakers to review them to make sure that we have reflected correctly what you wanted to say. We find these proceedings being used across Canada in many ways; so your discussions go far beyond this room. We hope that has an effect in the workplace--from many things we have heard, we feel sure that it does.

Our first session is a panel discussion on existing services. I am sorry that we do not have a representative from the Community Health Services in Quebec as was shown on your agenda. But I want to make it very clear it is not because Michel Guillemette has stood us up. His name appears on the agenda at my request because we wanted to quickly print and send the agenda. I had called Dr Guillemette, who kindly accepted to participate on the panel, but who almost immediately discovered that he had a date conflict. He tried very hard to find a replacement, but was unable to do so; he had the added difficulty that CCOHS's policy does not enable it to cover even our panelists' travel expenses. I want you to know how grateful we are that people are willing to do this for us time and time again. This is the first time we have had a difficulty and only because the person Dr Guillemette suggested to replace him is working on contract.

PANEL DISCUSSION

Existing Models of Health Services:

* Labour Clinic
* Employer Service Physician
* Free-Lance Service
* Occupational Health Nurse
* Employer Hygiene and Safety

LABOUR CLINIC

Lillian Vine

Our first speaker is Jill Marzetti. Jill holds an Honours BA in Political Science and Economics, an MA in Political Science, and a Masters of Industrial Relations, all from the University of Toronto. She has been employed as the Staffing Manager of the Nursing Department at Toronto General Hospital; as a Policy Research Consultant for the Ontario Women's Directorate identifying policy issues surrounding reproductive hazards in the workplace for women; as an organizer for the New Democratic Party of Ontario; and as a Research Assistant for the Registered Nurses' Association of Ontario doing a labour market study of the nursing shortage in Toronto and Ontario. She is now the Coordinator of the Health and Safety Clinics for the Ontario Federation of Labour. Jill is going to describe the model of service provided by these clinics.

Jill Marzetti - Health & Safety Clinics, Ontario Federation of Labour

Good morning. I am pleased to have the opportunity to speak at this workshop about our clinics. I see some familiar faces in the audience; I am pleased to see that there are labour people here as well as the people I would normally expect to see.

Our clinics are a new and innovative form of health care delivery in the province of Ontario. I would like to start with a brief overview on why we feel the clinics are important and why labour-controlled clinics in particular are important for us in the labour movement.

Those issues revolve around three words: availability, accessibility, and acceptability. We are all aware of the availability problem in Ontario in terms of occupational health physicians. We know that there are other professionals within the field, but the main problem for us in the labour movement has been at the physician end.

The problem of availability is simply that there are not enough people graduating from the school system. Post-graduate training is only available at McMaster University in Hamilton and the University of Toronto. The University of Toronto is cutting back next year on admissions into the public health program because they are reviewing their goals and the direction in which they are planning to take their medical program. We anticipate even more cutbacks at that time.

Also, until 1986, the Royal College did not recognize occupational medicine as a subspecialty. Looking at the supply and demand mechanism as it operates within the OMA scale, there is not enough incentive for people to enter this particular branch of medicine, there is not enough compensation for doing basic things in occupational medicine, such as doing a good occupational history. There has been a real problem with availability because of the low numbers of graduates of the programs.

There are also difficulties with the services that are presently provided. One study, done for the Task Force on Workplace Health and Safety for Metropolitan Toronto Health Council, indicated that for a medium-risk industry to provide a full occupational health service at approximately $100/employee, it would require an establishment employing a minimum of 600 people, and more appropriately 2,000, to operate on a cost-effective basis. Most of the employers in Ontario have establishments considerably smaller than 600 employees; the result is that most occupational health medicine personnel in Canada and the United States are employed in establishments of more than 500 employees. This concentration of caregivers with large employers leaves most workers without access at the workplace to trained occupational health professionals.

The other major issue is labour control; this, from our perspective, affects the question of acceptability. We recognize that a physician who is working for an employer is subject to conflicting demands--those of his/her professional ethics and those of responsibility to his/her employer. The literature is very clear that this is a major tension in any establishment; most researchers have recommended that health clinics in occupational health should be free-standing and staffed by physicians who are independent of employers.

Looking at the statistics from the Workers' Compensation Board, we know that compensation costs and compensation claims are rising at a severe rate. From 1980 to 1986, the settled claims for permanent disability from occupational disease have risen almost 50%; the increase for temporary compensation claims has been 25%. This is a major concern. The situation for permanent disability settled claims for injury worsened sharply for the 1980 to 1986 period; they rose 91% over 6 years. Figures that were made available to the Metropolitan District Health Council Task Force on Workplace Health and Safety 1984 indicated that an overall grand total for Schedule 1 employers of claims in the neighbourhood of 46,000 for a total cost of compensation of $76 million. The bulk of the claims originated in manufacturing, trade and service sectors; the bulk of these employers are establishments of fewer than 249 employees. The establishments in the 1 to 19 worker size, which are not required to have an occupational joint health committee, accounted for approximately 56% of the claims.

In terms of our own clinics, people from the Hamilton area will be aware of the long-standing proposal of the labour movement, particularly from the United Steelworkers of America, at the Hamilton and District Health Council for funding for clinics. This proposal languished for a long time because of the battle between the Ministry of Health and the Ministry of Labour. Last fall, events overtook this proposal; the request for funding was moved from the Ministry of Health to the Ministry of Labour. We have now received funding for a 3-year period.

The clinics that we are going to be operating will be located at 800 Barton Street East, Hamilton, and at 1478 Danforth Avenue, Toronto. I am pleased to say that both these clinics are opening within the next three months. We have a director on staff at each of them and we will be hiring staff very shortly. The mandate of these clinics is to do diagnosis and treatment of work-related illnesses for all workers in Ontario. It is not

only for the organized sector; we are looking for walk-in trade. We will be doing out-reach programs within the community aimed at the organized and unorganized and the community and environmental groups.

Our second major goal is prevention. We have a treatment focus now; prevention is our long-term goal. That will be accomplished through education and information. Some work on research will be included as well. We will be hiring physicians, nurse practitioners, hygienists, health educators, support staff, and administrators. We look forward to having links with the community and with teaching institutions.

Each of the clinics is structured as a non-profit corporation. There is a Board of Directors whose members are divided among labour, employers and health professionals. The labour representatives and the chairs have been appointed by the Ontario Federation of Labour; the Ministry of Labour has taken the responsibility for the other appointments. We have major employers represented on the Board. The health professional groups on each of the Boards are represented by one Chief Executive Officer from a major hospital; in Toronto it is Vic Stoughton from the General Hospital and in Hamilton it is Ray Walker from Chedoke-McMaster. We also have Susan French on the Hamilton Board who is from McMaster Nursing and the Health Council. In Toronto we have Sandy MacPherson, a former City Officer of Health, who is now teaching at McMaster University. This is a very representative, high-powered Board in both cases, because we have people who are extremely committed to the project. Certainly the Ontario Federation of Labour is committed to its success.

The main criterion or condition that was placed on the grant from the Ministry is that we operate on two different models and terms of provision of services. In Hamilton, we will be hiring people directly; in Toronto we will be hiring people from a third party. Essentially, that means that in Toronto we will be hiring the professional component from teaching hospitals. The Federation is hoping to have a network of clinics extending to Eastern and Northern Ontario particularly, where our members tell us there is a desperate need for independent medical assessment and education.

The services we are going to be providing are five-fold. We want to do independent medical assessments by independent persons on occupational health and safety. We will be providing industrial hygiene consultations and trying to make the necessary workplace connections. We want to provide education, information and advice in a form that is understandable and approachable for workers. This, from our perspective, is an empowerment issue; we want the clinic to be doing the education/ information provision to workers so that they can go back to the workplace and, through their joint health and safety committees, deal with the problems. The clinic does not have a mandate in the workplace; the affiliate and the local do. Our role is to provide the information they need to get the necessary changes in the workplace to make it safe and healthy.

Finally, there is the issue of compensation. Both Boards have, at this point, made a decision that we do not want to be overwhelmed by compensation claims. We recognize that we will be doing some third-party work on compensation, but we do not want to be totally overwhelmed with it.

EMPLOYER SERVICE PHYSICIAN

Lillian Vine

Next to speak is one of those "company doctors" that Jill was referring to. Dr Tony Hammer has been Manager, Occupational Health Services at Polysar Ltd in Sarnia since 1984. He is certified by the Canadian Board of Occupational Medicine and has been practising medicine for 15 years. He is a graduate of the University of London, England, and his background is in the armed forces and diving medicine.

Tony is also a very good friend to CCOHS. He was the requester of our very successful workshop on Drug Testing in the Workplace. We know that we can always depend on him to say yes when we call.

Tony Hammer - Polysar Limited

This is quite an auspicious occasion; I think it will probably be the last time I shall be described as working for Polysar because we are being taken over by Nova.

I should like to look at two particular areas of change that I think are taking place right now in the role of occupational health and safety professionals. First I would like to focus on the employee; later I will look at the employer. The employees are you and I; so let's look at how the image of our well-being has changed over recent years.

We are getting healthier; our life expectancy is increasing. Perinatal mortality, which is often used as a gauge of the health of the population, is declining. Paradoxically, we are worrying more and more about our health, and we have now redefined sickness to include the following:

- The potentially sick--for instance those with high blood cholesterol; much anxiety is expressed and many therapeutic steps are taken to counter the threat of ill health.
- Maladaptive behaviour--emotional distress, substance abuse. Are not our employee assistance programs playing a much larger role in supporting the welfare of the workforce than they ever did before?
- Child abuse.
- Hyperactivity.
- Unattractiveness, obesity, old age.

I am not trying to portray these as non-medical issues. However they have been brought into the medical sphere because they are best addressed by the medical and other professions in the course of the promotion of occupational health and safety in the workplace.

We want everything to be preventable or treatable. Canadians consume more prescription drugs than people in any other country in the world. Our expectations of being able to correct or treat whatever ails us are the highest. The medical industrial complex promotes the idea that everything disappointing or any discomfort or malfunction in our bodies can be corrected by some means or other. There are 2,000 drugs listed in the CPS, whereas the World Health Organization recommends that we only need 200 to look after our basic health and welfare.

We see the environment as the cause of much of our ill health. In fact, if we look at cancer, some say that 50% to 80% of cancers are caused by the environment; about 6% of these by the workplace. We see threats from the air, the water and the workplace. Many of these are real threats, but not all. Every illness and discomfort is the fertile soil in which health concerns take root.

The challenge for occupational health and safety professionals is to translate good health into a sense of well-being and security. It is only through a sense of well-being and security that we can achieve self-actualization. Our health is improving, but our ability to translate this into our own sense of well-being has been limited.

Another challenge for occupational health and safety professionals is whether we can explain minimal risk to workers without provoking inappropriate anxiety. Every risk that we are exposed to in the workplace is relative, but relative to what? We know that we cannot achieve a totally risk-free environment at home or at work. Yet when we confront risks in the workplace and respond to them, we haven't satisfactorily tackled the problem of conveying to workers how great that risk is. It is fine to say that there should be no risk or exposure, so there will be no disease. But is that realistic? If it is not, you may argue that it is preferable that workers stay at home, yet the home is not risk-free either.

The employee's attitude towards his or her own well-being is changing. This is a fairly recent development; we can go back 20 years and see that attitudes towards sickness and well-being were quite different.

I would like now to turn to the employer. I think the workplace is being cleaned up. Most large industries are spending from $150 to $250 per employee on occupational health services. For example, asbestos is being eliminated; chemical exposures are declining; ergonomic stresses are being reduced. Why are the employers doing this? One reason is undoubtedly that many of these changes are legislated. But, in fact, most large employers that I am familiar with have standards that exceed the requirements of the law. With my employer, for example, when we take permissible exposure levels of chemicals in the workplace there is an action level at half the permitted legal exposure. We don't regard the legislatures as being arbitrators of the exact exposure which results in adverse health effects.

I'm not sure that this is taking place with small employers. And there may be an increasing gap between large and small employers in this respect. The advances are taking place more among the large employers who have greater resources than the small employers. Many have an appreciation of the connection between the quality of their product and the quality of the treatment of their employees.

Figure 1

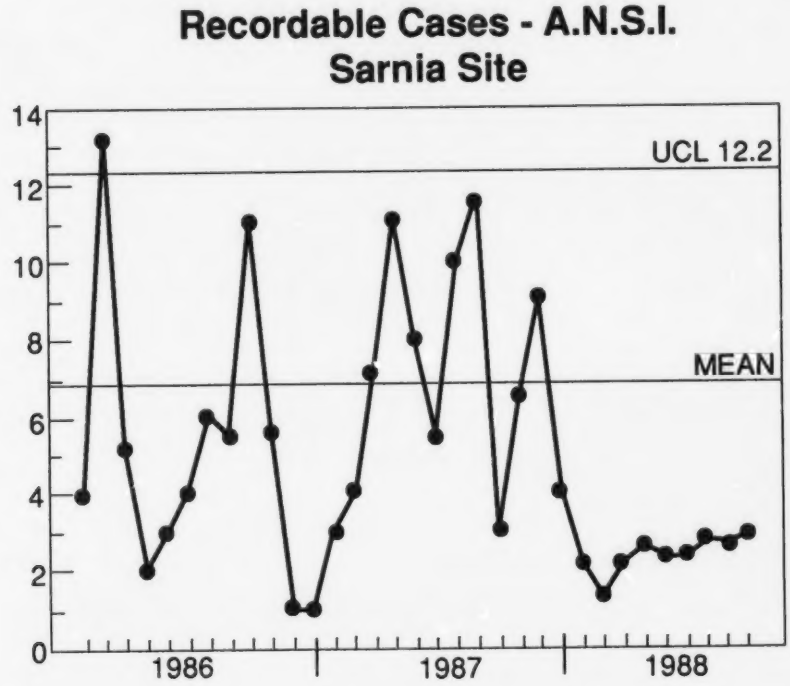
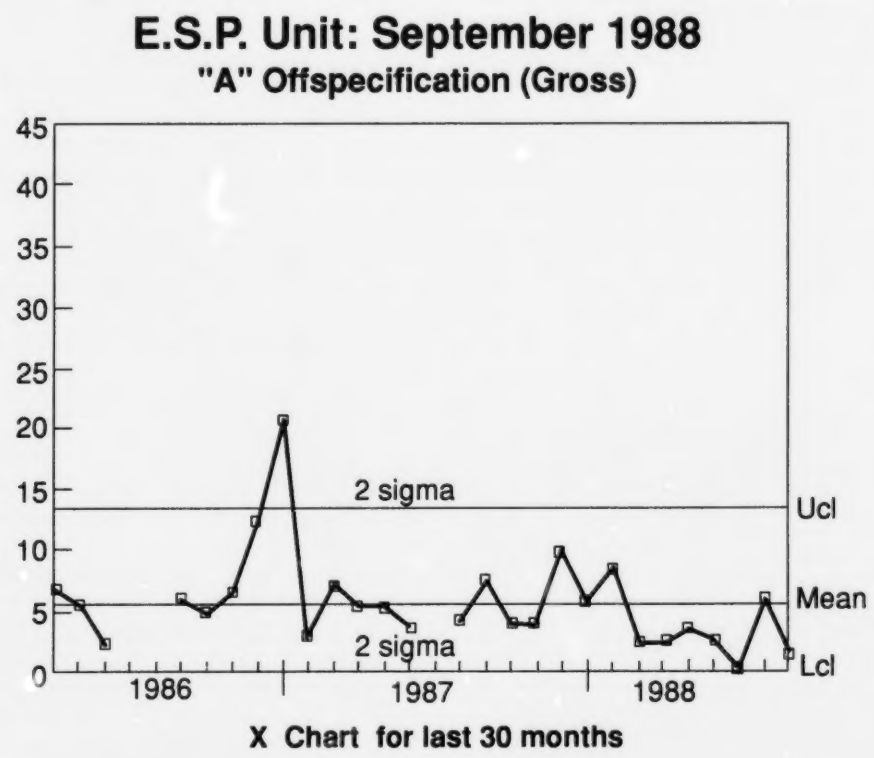


Figure 1 is a graph measuring recordable cases at the Sarnia site for WCB compensable injuries. The "Mean" line on the graph is the average of years past. Look at the wide variations at the beginning of 1986; that is the hallmark of an injury rate that is out of control. Toward the end of 1987, it came under control; this indicates an injury rate being managed. Prior to that date, senior management had accepted that injuries were inevitable, that there was not very much you could do about them, and that you had to take the flak when they occurred. They have discovered otherwise. They have also discovered something else.

Figure 2



Traditionally, a product that was made substandard was sold off at a reduced price. We discovered that the Japanese didn't do this. They didn't make "offspecification" product. They measured how much "offspec" there was and worked constantly at reducing it. You can see in Figure 2 that there is a decline in the "offspec" towards 1987; the mean level has dropped by about half. What I am showing here is a coincidence between the reduction in the WCB compensable cases at the site and a reduction in the "offspec" rubber that was produced.

This hasn't escaped management's attention. They have noticed that the quality of the product is a reflection of the way employees are treated. Companies cannot, in the long term, approach safety only; the big returns come from addressing the whole spectrum of needs of the employees themselves.

So, the demands of the employees are changing; their concerns about their well-being as they become healthier are becoming greater. We don't know if we can meet those demands; but it does take treating employees as people.

For example, many offices are laid out in such a way that there is too much reflection from the video display terminal; the chairs have no arm rests so there is stress on the shoulders; some of the old video display terminals are only about 1" above the keyboard which means the person's head has to be lowered to read the screen. It is very easy to lay out the workplace in such a way that these stresses are eliminated. But, what management has discovered for the first time is that 70% of the benefit derived from modifying the workplace comes from having the workers work in groups with an expert to explain the concepts, look at the alternatives and present to management these alternatives together with the cost effectiveness and the potential impact on productivity. I have never seen management say "No" to this approach. We will see more of this in the future because it also addresses the health concerns of the workers themselves.

FREE-LANCE SERVICE

Lillian Vine

Thank you very much, Tony. That was an interesting look at the changes in the attitude of companies toward the health of their employees, which in turn are leading to change in the role of the occupational health physician.

Jack Richman, our next speaker, is an "independent." He is a full-time occupational health physician, but he is not involved in the labour clinics nor is he employed by one company. Jack is a specialist in occupational medicine with 20 years of experience. He holds a diploma in Occupational Health and Safety from McMaster University. He is Board certified in Occupational Medicine, is a Fellow of the American College of Occupational Medicine and sits on its Board of Directors. He is also a certified member of the College of Family Physicians. Jack does consulting in occupational and environmental health as Managing Director of the Industrial Doctor and Medical Consultant to a number of companies which include St Lawrence Cement Company, GE Canada, Atomic Energy of Canada, Goodyear Canada, Woodbridge Foam, and the Hospital for Sick Children. Jack has authored several publications.

Jack Richman - The Industrial Doctor

I will speak about the role of an independent occupational health professional. Some professionals may find the "independent" gives them some difficulty and consider they are really employed by employers; but the employees too are employed by the employers and they get their paycheques from the same source as the independent or the company physician. One can give independent advice and expect the employer will accept that advice in good stride.

There have been many changes in the 20 years I have been in occupational medicine. The main one correlates with what Tony Hammer has said about the treatment of employees by employers. The attitude of the employer and the human resources department toward the employees determines the need for occupational health services. It is my opinion that neither independent clinics nor labour clinics would be necessary if employees felt that their employers saw them as part of a team. The whole team--the employer, the employee and the occupational health professional--should be working toward the same goals. That is not always what happens and so we have labour and independent clinics.

Jill chose essential criteria: availability, accessibility and acceptability. Those are the keys for any independent clinic. But I don't believe that labour control is needed; I think labour control poses its own problems. The physician, whether under the control of the employer or labour, can be subject to the politics within a company or union. Some unions demand information and knowledge, which is good; but some also demand input into how the medical program should be run and that creates an ethical issue. Just as it is wrong for employers to do that, it is also wrong for labour. The primary client is the employee. If one looks after the health and well-being of the employee, the employer has a healthy, happy employee who will work well; this satisfies everyone. I have found over the years that what is in the best interest of the employee is usually also in the best interest of the employer.

I also find that many, if not most, employees do not want labour-controlled clinics any more than they want management-controlled clinics. They would like to feel that the person who is looking after them, irrespective of where s/he comes from, is independently looking after their individual well-being. The difficulty arises, not in who has the control, but in the rules and guidelines health professionals have to follow. One thing that has not been addressed to date but is coming up in the new draft, is that the procedure which the professional follows should be legislated so that neither the employer nor the union can control it. That is a very important issue because unfortunately many professionals are under pressure, both from the union and the employer. It is unfortunate that that kind of pressure can cause the entire profession to be labelled. That is non-productive; it only sets up a battleground for confrontation even within the profession and it doesn't help the employee. If we are looking at prevention and helping the employee, what is important is not who pays for the activity but the conduct of the professional carrying out the activity.

In freelance consulting, I am concerned with the best interests of the employee, and employers find that this is in their own best interests. No matter how much money is spent, there is always an increase in productivity because the employees feel they are part of a company that has an interest in their well-being.

Employees have anxieties about what is happening and they have a legitimate right to answers to their questions. If they are not answered in the workplace, they seek those answers from their own physicians, who often are not knowledgeable about the workplace, or from independent clinics or from labour-controlled clinics. No longer can employers patronize employees. People are better educated. They want to know what they are being exposed to and they have a right to that information.

One of the services provided by independents is the treatment of injured workers. Another is determination of fitness for work, either pre-employment, pre-placement or in the return to work after an injury or illness. Last is medical surveillance--following the health of the workers during their working lifetime. By medical surveillance I am not referring to just designated substances; I feel that is somewhat narrow. I like to look at programs we can use to prevent illness in the future; ones that employers will spend the money on to improve the health of the worker as well as increase productivity and product quality.

I believe that all people can have a healthy productive work life and that it is important to return people to the workplace as quickly as possible after an injury or illness. If they feel they cannot return to work, this creates a negative effect; and people will come to expect that when they get any little illness they will be off work. It is not only not in their best interests, it is also not in the best interest of the employer or society at large. A number of studies have shown that no matter how long a person is chronically off work, the long-term prognosis doesn't change very much if s/he does not return to work early. An early return to work is much more beneficial from a psychological point of view. The philosophy of our clinics is to return the employee to work as soon as possible; it is the responsibility of the employer to provide appropriate work that will not aggravate the employee's condition. The physician should provide information to the employer about what the patient can and cannot do and let the employer make the decision about whether or not that work is available. This is where communication plays a part. Employers, employees, unions--everyone should together determine what is the best interests of everyone and work out some policies. One of the things that we, as independents, do is to try to get that communication going. Once is gets going it works very well. When you return people to appropriate work, you must make sure that the employee, the employer, and the union understand what the objectives are. Everyone must work together to achieve those objectives. It doesn't matter who controls the clinic; what matters is the attitude of everyone involved.

The other difficulty I have is the number of absences caused by concern and anxiety. At McMaster University, a study was done on hypertension on a number of employees with high blood pressure. The employees were divided into two groups. One group was told they had high blood pressure; the other group was not told. The group who had been told had greater absenteeism and increased illness which they related to their high blood pressure. The group who was not told returned to work on a regular basis and continued working in a normal fashion. If we raise the anxiety level of people, the reasons for their absences and illnesses is often that we have raised their awareness. Therefore, how we tell people things is very important. We must evaluate the situation in an objective way and keep the employees informed without raising their anxiety level.

OCCUPATIONAL HEALTH NURSE

Lillian Vine

Thank you very much Jack. Jack Richman, Jan Logan and Clyde Hertzman formed the group that planned the agenda for this workshop. Clyde was involved from the early planning in January, cleared the date long ago, then found the date of a previous obligation changed to today; he was very disappointed not to be here.

The important role of the occupational health nurse has become more and more recognized. We have with us the President of the Ontario Occupational Health Nurses Association, Judith Pope. Judith is the Head Nurse, Occupational Health Department, and the Manager, Employee Assistance Program for Union Carbide of Canada in Welland. She is a Hospital Trustee of Welland County General Hospital. She graduated from the nursing program at the Greater Niagara General Hospital; she is registered with the College of Nurses and is a Canadian Certified Occupational Health Nurse.

Judith Pope - Ontario Occupational Health Nurses Association

I will speak first about the different types of occupational health nursing models across the country; I will then expand in detail about the most typical model, which is the setting where I work.

The large companies across Canada (such as Dofasco, Stelco, General Motors, Ford) employ multiple health professionals on a team with many nurses coordinated by a nurse manager. These units are usually on one site. The large corporations with multiple office sites across Canada (such as Bell Canada, Ontario Hydro, CIL, Canada Post) have a corporate centre with direction from a corporate head office and a different nurse at each site. The medium-sized employers (such as the 222 public hospitals in Ontario, or independent companies with only on-site management) have the most difficult occupational health departments to operate, because these nurses often work alone and do not have much direction or support from someone in a corporate office. The small companies, however, do something totally different. Often two or three industries share a nurse. The newest trend is to contract out to a private company such as Employeecare or The Company Nurse. I would not suggest that nursing placement services be used because these nurses are experts in home care and hospital care; they are not specialists in occupational health nursing.

The majority of occupational health nurses across this province work for large heavy-manufacturing companies employing between 600 to 1000 workers. I would recommend that you hire only a registered nurse who has a current certificate with the College of Nurses. The employer is responsible for obtaining a copy of that certificate which is issued on a yearly basis. Encourage your nurse to write a certification examination which will ensure that s/he has mastered a body of knowledge and acquired skills in this specialty. This is a CCOHN (Canadian Certified Occupational Health Nurse) and this is the first nursing specialty in Canada to set such an examination process.

This nurse can walk into any Ontario workplace and bring to it the best deal for the money paid. S/he is capable of assessing the particular needs of that company; s/he is knowledgeable in terms of the legislation that must be complied with; s/he knows how to follow the regulations to comply with the designated substances regulations; s/he has skills that allow him/her to set in place health surveillance programs; and s/he knows what health promotion programs are needed to keep employees well. This nurse needs to have some entrepreneurial flair to design programs that are unique to the specific industry.

Give this nurse authority and responsibility and s/he will earn trust. S/he will offer managerial skills and become a knowledge resource to his/her employer on occupational health and safety issues.

Occupational health nursing is increasingly adopting a holistic approach to health care in the workplace. The worker and the work process should be compatible to promote total well-being--physically, mentally, and socially. Management support at the highest level is a vital component of any and all occupational health services.

The three major roles within our conceptual framework are education, treatment and prevention. Science is developing a growing body of knowledge about acute and chronic problems related to work. The occupational health nurse must be aware of the recommended standards of safety for equipment and new techniques to prevent accident and injury. Once, many health problems were felt to be just part of a job; workers would resign themselves to a life of repetitive strain injury, hearing loss or respiratory problems. But, by knowing the "why" and the "how," the problems and the solutions to those problems, both the worker and the professional can join together to eliminate the causes of poor health. One approach is through the application of ergonomic research. We now recognize physical differences in employees and how they interact with the workplace. The result, of course, will be improved productivity with decreased physical and psychological strain.

New technologies can create new hazards; current knowledge of the effect of exposure to chemicals, dust and fumes allow the occupational health nurse to meet these new challenges through the education and protection of the workforce. Launching new health education programs in the workplace requires a working knowledge of adult education. Presentations relevant to the needs of adult learners will give programs a very strong start. The nurse can then follow up and evaluate results to ensure that the program is understood and that the objectives were truly met. It often requires considerable effort to ensure that occupational health is a top-of-the-mind concern in the workplace--not just once in a while, but every hour of every day. As educators, we teach fellow employees to be healthy and to be their very best.

Often, people think that treatment is the professional's only function; in heavy industry the actual hands-on care for trauma is approximately 5% of the nurse's time. But still one must be prepared every time the phone rings for a potential serious injury or illness.

Our involvement in prevention involves surveillance and health promotion programs. Preventive health care is the art of treating the well. The primary objective of an occupational health service is maintaining good health by preventing injury and disease in employees. Screening programs are a common starting point, designed to be job-related and hazard-specific so they can assist in ensuring appropriate treatment and placement of employees according to their fitness for the task.

Records of employee health and health problems help the nurse to identify recurring problems for individuals or changes in the overall health of the company. Statistical analysis provides the means to isolate problems and plan effectively to solve them.

Confidentiality of health records is the foundation of a successful occupational health service. Mutual trust between the nurse and the employee is most essential; s/he is not a policeman in your workplace. Many companies now formalize procedures for handling employee information to preserve the confidentiality needed for proper occupational health care.

With personal knowledge of the workplace and a solid grounding in scientific research methods, the nurse can now track health data, reveal trends, pinpoint potential problems and evaluate the success of the occupational health programs s/he has in place.

Here are some of the programs we have at Union Carbide; they are evergreen, they are flexible, they change--we add, we delete, and we repeat. We immunize against tetanus, polio and diphtheria, and in a workforce of 720 people we have only 5 who prefer not to be immunized. We run a back-care program, a skin-care program, a skin-protection program, a respirator program, a hearing conservation program, anti-hypertensive screening program and, most importantly, a follow-up to that program. We also do stress counselling and an employee assistance program which includes alcohol and drug-abuse programs which can lead to subsequent policy development or changes. We do WHMIS teaching. Education on a variety of subjects is often run in safety meetings; we have done workshops on diabetic care, dealing with death and the grieving process, alcoholism, cholesterol reduction and family violence.

Beyond the formal health care programs, the occupational health nurse is a continuous presence in the workplace. S/he represents the importance of employee health and uses every opportunity to encourage support and participation. Some occupational health programs take place on a more individual level and the occupational health nurse can spend much time counselling workers. The nurse becomes someone to trust, someone with special listening skills, someone with access to community resource agencies where specialized help is available to every troubled employee. After all, people are a company's greatest asset. If we keep employees fit, they are productive.

Through education, treatment and prevention, the nurse can ensure that s/he remains a key member of the occupational health team. A field full of challenge and creative opportunity and reward are there for occupational health nurses to experience.

EMPLOYER HYGIENE AND SAFETY

Lillian Vine

Our last speaker is the person who started this process. About a year ago, she met our President at a meeting. They talked about occupational safety and health developments that were changing the role of professionals--some for the good and some for the not-so-good. She thought it might be a good idea to discuss changes and stresses and solutions and that's why we are here today.

Jan Logan is the Director, Occupational Hygiene and Safety for Northern Telecom Canada Limited. She has a degree in chemistry and physics and she has worked in the industry for 13 years, 9 of which have been in health, safety and environment. At Northern Telecom, the team introduced the Health and Safety Program in 1987 to provide a common approach to managing health and safety in a decentralized environment.

To speak about occupational hygiene and safety in an employer service is Jan Logan.

Jan Logan - Northern Telecom Canada Limited

The changing roles of occupational health and safety professionals is a worthwhile question to explore. I hope we will join together in the workshops to share the most meaningful exploration.

I want to touch on three areas and consider what we have in terms of today's programs and activities. I want to look at a few of the problems and at what might be the opportunities for change and for improvement.

Duties of people who work in the industrial hygiene and safety fields include recognizing problems and using the professional skills that we have to evaluate those problems. There are some important and complicated skills that can help in the evaluation. In the occupational hygiene and safety field, there are professional qualifications. Things are changing; when I first entered the field it was rare to find people with professional accreditation. Now, there is certification for industrial hygiene through the American Board as well as the Canadian Board. In the safety area, there is the Canadian Registered Safety Professional and also an American equivalent. It was also rare to find people in those areas with strong academic backgrounds. Today, that is not the case; there are more and more, to the benefit of the profession.

Once we evaluate the problem, we try to eliminate it, substitute a less hazardous product, or control the exposure to that product to make the workplace safer. If we can eliminate the problem altogether, that is for the best. In some cases, we control the problem by keeping exposure to the lowest possible measure.

In responding to WHMIS and in promoting our own health and safety programs, we looked at problems that are common throughout the company such as chemical safety, ergonomics, machine or robotic safety. We chose to work on chemical safety first because WHMIS was coming along. In the design of our chemical safety training program, we felt it was important to not only inform employees of the hazards of the chemicals they were working with but also to control and eliminate those hazards to lessen the anxiety level. We also looked at what monitoring of the workplace was needed to ensure that workers were not exposed to a particular hazard.

We control the hazards, but we must also inform employees. Education and information are extremely important. I believe that having people understand what they are working with is a better situation than just telling them what to do without explanation. To participate fully in the work, the worker needs a basis to make a personal decision. There is no worse situation than not understanding what is going on around you. This

exercise with respect to educating in chemical safety has been interesting and worthwhile; it is very satisfying when you see the interest people have in gaining more information. When it is explained in a clear, straight-forward manner, people can understand and this will give them a good basis for participating in workplace decisions.

Reviewing and modifying the controls and programs are essential. Those initiatives have to be reviewed and, if necessary, be modified to reflect what is going on in the workplace.

One of the questions is who will do all of these things? I think this is where one of the changes is taking place. Health and safety professionals have traditionally worked in these areas and they will continue to do so; but I think the role of the health and safety committee is expanding. Some companies had already established health and safety committees before legislation brought them into being. Initially, some of these committees were ineffectual and this was, to some extent, due to lack of training. For health and safety committee training, we are looking at more than just the subject area; we are looking at the whole area of group dynamics or working as an effective team. If you can't work together as a group then what you are trying to achieve will not be effective. Management and employees will be involved to some extent in these kinds of activities and I believe they can take a greater role than they have in the past. We have some good examples at Northern Telecom of employees becoming involved in committees; one that is working well is in the area of ergonomics. We started out with one committee made up of managers and employees working on ergonomic problems in a plant; now we have three. Each committee is in charge of a different area in the plant; they have been retrained to do the recognition and evaluation, they plan the recommendations and make presentations to management and then monitor the implementation. It is going beautifully; the fact that there are now three committees attests to the success of the approach.

In the sector I represent, which is light manufacturing companies, we do not see critical injuries to the extent that we did in the past. Strains, sprains and ergonomic injuries are much more the problem. We also see concerns about comfort--whether the employee feels good or not. This might be related to psychological health or physical environment. Air quality is becoming a serious concern. Environmental illnesses, stress--these are concerns that are not going to go away and there is an increase in compensation for them.

We have to live with the fact that in some sectors of industry there are ongoing high injury rates and deaths. We have another sector which I call the "no control sector." In the medium and small companies there is often less emphasis on health and safety. There is concern among professionals about how to deal with small companies which have no controls on health and safety concerns. This is not an easy question to answer. We see rising workers' compensation costs and more interest in society and the media--which sometimes inflames the situation.

There are new government initiatives. An example in Ontario is the Joint Steering Committee on Hazardous Substances in the Workplace, which is a committee composed of 9 representatives from employers and 9 representatives from labour. We are looking at an alter- native to how we typically manage dangerous substances such as designated substances. The labour clinics are another example of new government initiatives.

There is increased labour movement activity in the occupational health and safety area--the Workers' Health and Safety Centre is a good example of that.

In industry, there is management anxiety and there are pressures. Management wants to do the right things but sees the rising costs and rising accidents. Management wants good publicity and good productivity, but also must meet time and cost pressures to stay in business. This is part of the scene that we are dealing with today.

When we look at tomorrow, the key is prevention. How can we prevent injuries and illnesses in the workplace? The "how" is important. Involvement, participation, partnership, education/information are some of the keys. In talking to managers about accidents or absences due to illness, one of the key things that comes out is that people come to work if they want to be there. Many studies have shown that money is not the primary reason for coming to work--satisfaction, involvement, a feeling that you have contributed something, doing something worthwhile has a lot to do with why people come to work. If that positive feeling isn't there, employees are not going to have much reason to come to work in the morning. If the employee is not feeling that well or if there is an ergonomic problem at work, this will be an incentive to stay at home. So we need to work at motivating people to come to work and this can be accomplished by involving people in their work and in designing their work process.

Who are these people? Managers and employees who need to be involved and be informed adequately so they can contribute. Health and safety committees working effectively and actively. Health and safety professionals not only in their professional and technical roles but also in a leading and coaching role can be useful.

Another area that hasn't been touched on but is something that might be worth looking at is the network of contractors and sub-contractors and suppliers who feed into the larger companies. When we look at injuries, many of them are happening in the small and medium-sized industries. How can we help that situation? We can share and assist these companies that make up a company's network and help them to get some of the controls in place to improve their workplaces. The Japanese model is working together with your supplier and contractors so that together you succeed. In North America, we insist on a certain level of quality in the product you get from that contractor or supplier. Quality is not limited to management of workplace health and safety concerns. Also important is outreach to the family and community--health and safety doesn't start and stop when you come in or out the door. You bring to the workplace your personal health and family and community concerns and when you leave the workplace some of the education we have implemented there may have some effect on health in the community. It all works together to help improve both personal health and occupational health.

QUESTIONS AND DISCUSSION

Vic Barker - Occugiene International Inc

I am a practising occupational hygienist, President of a company that specializes in occupational hygiene and also President of the Canadian Registration Board on Occupational Hygienists. I want to offer to CCOHS congratulations and thanks for putting together a program like this. It comes at a very appropriate time for occupational hygienists.

I would like to offer a criticism. Jan did a valiant job in trying to present the occupational hygiene professionals' side, the occupational safety side, but the rest of the panel spoke about occupational medicine and nursing. There seems to be a bit of a bias there. I hope that in the workshops this bias is recognized and that we take into account that doctors and nurses are not the only professionals on the occupational health and safety scene.

I would also like to make a comment. I am very concerned about the role that politics plays in the occupational health and safety profession. We see a representative from labour, we see a representative from the employer--what has this got to do with being a professional? Let's look at it from the point of view of the OH&S professional rather than for whom they happen to be working. This is harmful to the position of the OH&S professional and I hope this point is taken into account in the workshops.

My question is how does the panel define "independent"? I have heard "independent" used by at least two of the speakers and I don't agree with one of them. We need to define this term.

Jack Richman

I would define an independent as a person who has no biases. What we have to do is focus on the goals and objectives of the OH&S professional. If we all had the same goal then I would consider that we would all be independent. We have not come to that point yet.

Jill Marzetti

I don't think, in terms of our clinic's staff, we are asking our people to prostitute their professional standards. I don't think that their judgment is flawed if they are working for management versus labour. What we see happening is people being used as hired guns on both sides of the table. What we look for when we hire people for the clinic is the ability to exercise professional judgment. All information goes to the worker. We don' expect things to be necessarily any different when professionals, whatever level they may be at, work at our clinics versus those at Jack's clinics or for an employer health service. It is the utilization of the information that is the key.

Tony Hammer

I find it very difficult to respond without inflaming the situation. I think some of the labour people possibly underestimate the respect that we in industry accord them. We are all products of our environment--we have a perspective and they have a perspective. I know employers that use union representation on selection committees for occupational health positions; I would be quite prepared to do this in the case of industrial hygienists as well. I have seen as many people adversely affected by a collective agreement as I have by management actions. Jill may conclude that management actions such as layoffs during economic recessions are a political issue. I would regard it as part of the vagaries of the economy and something we must all face up to. Management has some very specific responsibilities under the Occupational Health and Safety Act as do

hygienists and, in fact, all occupational health and safety professionals. At the moment, the unions' responsibilities are simply to attend the joint health and safety committee meetings. They have no managerial responsibilities, and I think that situation needs to be rectified before we can become equal partners.

Peter Stopford - Ontario Hydro

We do have, in Ontario Hydro, a number of health hygienists on staff and I, as safety officer, rely on their expertise as I cannot be a specialist in all fields. In the same way, I rely on the man and woman in the workplace. I am not a millwright, I am not a boilermaker--they are. So if I need to know something about the hazards in millwrighting, boilermaking, or whatever, I need to reach out to a team member who does that particular type of work. I have to sit down with that individual and outline our position and get his or her input. Let's work at being team members, not individual groups of management or professionals or labour.

My question deals with contractors and sub-contractors, which is a problem with us. We have a floating core of our own construction people who remain at the plant indefinitely. If we get into a shut-down situation or if we build an addition to the plant, we bring in contractors and sub-contractors from outside. We find that these workers are not familiar with heavy water plants. We have a program where they spend at least two days with our safety department going through procedures before they go onto the worksite, where they are monitored by Ontario Hydro skilled personnel. The problem and the question--I constantly have battles with construction superintendents who do not want to have their employees spending two days in unproductive work. How can we address this problem?

My second questions deals with management responsibility toward the worker. How would you change the attitudes of some dyed-in-the-wool reactionary managers who feel that if one worker won't do it, they will get somebody else who will.

Jack Richman

About the cost in terms of money and time, I have two standard answers. The first is that the company may lose productivity now, but when people learn how to do a job safely productivity will improve in the long term. This answer seems to have little impact. The second, which has more impact, is that if a person has an accident, the whole place will have to shut down anyway--what will that cost? And what about the time management spends deciding how to respond to the press and the union? Does management want to take that kind of responsibility? When faced with these choices, I find managers make time and money available for safety programs. The issue seems to be how it impacts on each manager directly.

Judith Pope

I would like to comment on the problem of top management support. That is where the answer lies--you have to get top management to recognize it and get it on paper in

policy. In my company, we have bricklayers who come in on a two-week basis. We are responsible for their safety--they are exposed to silica and to noise. We teach them, we supply them with hearing protection, we supply them with face masks and we teach them why they need to protect themselves. They take that knowledge with them to other worksites. If you don't have top management support, you are in trouble.

Jan Logan

Certainly, getting top management support is a key. One of the other areas involves the purchasing team--the team that has a fair bit to do with buying the services outside the company. They have to determine if the company is looking for what it can get most cheaply right now or what in the longer term will be the best investment. I don't suggest that this is something that can be solved overnight--it doesn't usually happen that quickly. I have seen improvements when purchasing agents and people who write specifications for the job are better informed. Part of the chemical safety program I mentioned earlier was the development of two levels--one for the employees who work with the chemicals and an expanded program for other people including purchasing agents and managers to help them better understand the larger issues that are involved. One of the modules addresses these kinds of questions.

Tony Hammer

May I ask if you arranged with the contractors and subcontractors for their obligations under the Occupational Health and Safety Act to be incorporated into their contract?

Peter Stopford

Yes, it is part and parcel of their contractual arrangement. We have found that they look at these arrangements, they agree and then they bid for the job--the lowest bid gets the job. When they arrive on site the penny finally drops--they have committed themselves and they have to go through with the process.

We don't actually have that problem, but I am concerned with the transient construction workers who come to our site and learn all this safety information and then go away. I then get calls telling me that when they go to other jobs, they ask for the protective equipment we told them they need when working with a specific substance. Unfortunately, their employer does not always comply and these workers are concerned, as I am. The construction industry is rife with this kind of situation.

Tony Hammer

I agree and we have had similar experiences. I would really encourage the unions to put into effect the right to refuse work. There are two Occupational Health and Safety Acts--one is for constructors and one is not. In general, the standards for the constructors' Occupational Health and Safety Act in Ontario is lower than the manufacturing Act. We have come to the conclusion that whoever runs the plant is

responsible for everything that goes on in that plant; there is virtually no way except by providing absolutely no advice--by not acknowledging the slightest responsibility from the word go, which is immoral--to incur no liability at all. Those companies that do safety briefings incur liability. In fact, you have to regard all your contractors as being covered by exactly the same regulations as your employees and your responsibilities are exactly the same. You are incompetent if you employ incompetent contractors--you are liable. If you don't take sensible measures to ensure that your contractors are acting responsibly, you are liable.

J A Callaghan - Canadian Brotherhood of Railway, Transport and General Workers

The panel mentioned returning workers as quickly as possible to the worksite in occupations that perhaps would not be similar to the one they left prior to an injury or accident. There has been resistance by some employers. How do we get employers and management to recognize the social and well-being need to do that, not only for the worker but also for the company itself in the long term?

I also heard reference to clinics controlled by labour. I think the only objective should be the benefit of the individual no matter who is controlling it. The panelists talked of the organized worker, the unions. Let us remember that only 37% of the workforce in Canada is unionized. What do we do about the thousands and thousands of men and women who don't have the instrument of a union to protect their rights under employment legislation? How do we address that?

Jack Richman

I would like to comment first on modified duties. That is a difficult concept and the problem seems to be with first-line supervision. The supervisor gets a double message--s/he must produce a high-quality product at a certain number per hour regardless of anything. If someone gets hurt, s/he is supposed to provide some modified duties. But in the end, the supervisor is judged not on what s/he does for the employee but what s/he does in terms of productivity. If productivity is down because one of the workers is only doing 70% of the job due to modified duties, the supervisor is penalized. Management does not ask how the workers are doing, they ask how much was produced last month. I feel that a supervisor should not be charged against his/her budget for providing modified duties so that it does not become a disincentive. The company should have a separate budget for rehabilitation. The company benefits because it does not incur the cost of the compensation for the worker, and if the worker's full-time position is filled temporarily, there is actually more productivity.

Supervisors, if they keep the worker on, shouldn't incur costs but if they send the worker home, they should; that would be an incentive. That is the only way this can work. But management has to recognize it and be prepared to set aside a budget for rehabilitation.

Unorganized workers have benefited to a large degree by what organized labour has done. But they still are in many ways unprotected. Legislation has tried to help them get organized in terms of joint health and safety committees, but many times they are ineffective. There must be more power given to joint health and safety committees, especially in unorganized labour.

Judith Pope

It is really important to give meaningful work to an employee on a modified duty program. It is harmful for an employee's morale to have to perform trivial tasks; if the company decides to offer light work, then it should be done properly. I have never run into such a problem with management; what I have found is that the family doctor will recommend that the worker take time off work. That is where the problem lies--how do we educate the family doctor who has not been inside a heavy-industry company and who doesn't realize that light-work programs are available?

Jill Marzetti - Toronto Workers' Health & Safety Legal Clinic

Some may not be aware that the provincial government is funding a new legal aid clinic for occupational health for unorganized workers. It is located in Toronto and is called the Toronto Legal Health and Safety Clinic. It is not getting as much business as initially might have been anticipated. In our clinics, we are going to do a lot about re- educating and we hope that will reach the unorganized workers and encourage them to come in for the kind of education they need. But the bottom line from our perspective is that when you have an occupational health and safety problem, in the long run your best bet is to get a union.

Sharon Matthias - Alberta Health

I very much enjoyed the comments from the panel, but I am concerned that the panelists limited themselves so much. Before we go into the workshops, I want to remind people that if we are going to talk about the changing role of occupational health and safety professionals, then we need to leave the boundaries that we have lived in for a long time. We are living in a larger world and in that larger world there are a lot of people starting to get very interested in occupational health and safety. Environmental health and health issues generally are much more on the agenda than they used to be and the role of the professional in health and safety will therefore change very dramatically. I know the Premier's Council in Ontario mentioned this and certainly the Alberta Premier's Council on future health care needs of Albertans is looking at prevention, and health and safety is a big part of that.

Lillian Vine

That's why we are here today. Our panelists were to set the background of traditional roles and they went beyond that. How we deal with future changes is the very purpose for this workshop.

After the break, participants will go into workgroups. At the end of two sessions, the groups will report back.

PLENARY REPORTS OF WORKGROUPS

* Agreements and Disagreements
* A Way Forward

REPORT OF WORKGROUP #1

Lillian Vine

During the workgroup sessions, I dropped in on each group and was happy to see everyone participating. I saw something which warmed my heart because it is the very reason our Council decided we should do workshops. I saw people from very different backgrounds come to a lot of consensus on some very difficult issues. It was very interesting that it took a lot of time to discuss a question which might appear very simple--how do you define an occupational health and safety professional? It turned out to be a far less easy question to answer than they had thought.

Jack Richman chaired Workgroup #1 and will also act as rapporteur.

Jack Richman

Workgroup #1, in working on the definition of occupational health and safety professionals, considered several issues. We tried to determine the difference between a professional and a non-professional and the activities in occupational health and safety.

We expect the professional would have specialized knowledge, qualifications, expertise, training, and a degree of commitment. This covers many disciplines--occupational hygiene, occupational medicine, occupational nursing, occupational safety and ergonomics.

We looked also at who people report to and their job function. Do they manage their job, do they manage a function, do they manage people? We also looked at responsibility and whether it was responsibility with or without authority, as a decision-maker and with what degree of influence? Do they provide a service or advice only? Finally, we looked for a commonality, the raison d'être, a common goal that would make this definition. We examined prevention, health, and safety in the workplace. Out of this we came up with a definition of an occupational health and safety professional as:

> One who by training, qualifications and expertise works in the field of occupational health and safety for the provision of a safe and healthy workplace for the improvement and preservation of the employees' total well-being.

We, as a group made up of occupational hygienists, safety personnel, nurses and doctors, felt that that covered the ground of where our commonality is.

We then looked at the roles, both traditional and developing ones. We developed a list of traits of traditional roles:

a) territorial behaviour, which we felt was not healthy;
b) focus on the sickness model, which is reactive;
c) adversarial positions based on ignorance of others' activities and roles;
d) driven by cost and Workers' Compensation rather than by employee care;
e) looking at the efficiency of the worker rather than the worker's health;

f) advisory in many ways;
g) poor representation of safety and hygiene.

In the developing role, we found that teaching and the education of workers and management became a priority. The developing role deals with prevention, is proactive and multidisciplinary. There is a team approach with interest in what others do. There is a commitment towards technology and skills development and a demand for training by and for the occupational health and safety professional and a recognition of what we are doing. This is how we feel the roles have been developing.

REPORT OF WORKGROUP #2

Jim Ogilvie - Imperial Oil Limited

We didn't come up with a definition of an occupational health and safety professional; we came up with some concepts.

We agreed that it is a multi-faceted discipline; that it involves but isn't limited to the recognition, evaluation and treatment of disease and injury. It includes information obtained on the job--a health professional should be accredited and/or be recognized by the workforce as a professional. Everyone agreed that s/he had achieved some kind of specialized education in a related field; that a "professional" participates in programs which increase his/her health and safety knowledge. The professional must participate in ongoing education. Perhaps it is a person who through experience, qualification or ability is recognized in the workplace as an occupational health and safety professional.

During the second session, we discussed the issues that were pushing for change. There is increased complexity of legislation. But more, an increased awareness is pushing change in the role of the health professional. Management is starting to recognize that health and safety are part of good business and are part of the cost of doing business. Also pushing the health professional toward change is an increased expectation of a pain-free and stress-free work environment and less acceptance of health problems.

REPORT OF WORKGROUP #3

Peter Stopford - Ontario Hydro

Tom Murphy was the chairman of Workgroup #3. He started off by commenting that he, as President of the CSSE (Canadian Society of Safety Engineering) and a member of CRSP (Canadian Registered Safety Professionals), feels we all have vested interests in these proceedings.

We looked in depth for a definition of an occupational health and safety professional. We looked at the historical background of what things happened in the past and of how people viewed us as policeman; we realized that we have to use various specialists in the

field of health and safety constantly to achieve the role into which we are heading today. We need the feedback of the results of various tests and products in the workplace and we need to know how they affect various individuals. We need to know the causes of industrial diseases. So we need the expertise of nurses, doctors, health hygienists, and technologists of various kinds. We know that the Canadian Centre for Occupational Health and Safety is an excellent medium to disseminate this information. But we realize many in the safety profession still have not got the word that this facility is available to them.

We did come to a consensus on definition: that a full-time health and safety person is a team member whose energy is directed into providing a safe working environment for employees. On that team will be health hygienists, doctors, nurses, union health and safety representatives and others who have expertise they can impart to the team. The safety person is not a quarterback, telling the team where to go or what touchdowns to make. The safety and health person is someone who is seen as a coach.

The definition is "a team member or a coach of a team which includes management, labour and various professionals that feed information into the team."

What are the issues pushing for change? There is a pressing need out in the workplace for information. People are becoming more aware of the hazards in their workplace. Full-time safety persons need to know the changes that people expect in their workplace. People want to know that their quality of life will not diminish because of the employment they have chosen.

None of us knows everything; we need to rely upon people in the workplace, people in laboratories, health hygienists, scientists, doctors, nurses, and that means teamwork. We need to equip the people to know where and how to handle various substances in the workplace. To perform this function, the full-time health and safety person ideally should have some formal training and background in health and safety, but still be open to change and to information from other avenues which can affect the workplace. Jan Logan came up with the phrase "acceptable behaviour." We need to address what is acceptable behaviour in the workplace; how does it impact on our people? Can we change? How do we change some of the mental attitudes of not only workers but managers as well?

We now have the WHMIS legislation and we have Occupational Health and Safety Acts. All of these are driving us to open up information to other than professionals. This led us into a terrific discussion about how this was great for large corporations--we have budget and expertise to rely upon. But what about the smaller business that does not have unionized labour and expertise from union health and safety representatives? While we from our large business advantage can say that we have everything in place, as safety people we should also be concerned about helping those who do not.

We have legislation in place. People have the right to know. But in many of the small businesses, they don't know. People are suffering. We, as health and safety people, can gain credibility by being concerned with more than our own bailiwick. We need to be concerned about others; we need to be concerned about their situations. One suggestion was to adopt a small business. I like that suggestion. We can offer safety seminars to a small business and I am sure that approached in the right way, management will back these programs because it is good public relations. I personally will take that suggestion back with me and try to implement it.

QUESTIONS AND DISCUSSION

Lillian Vine

The words that have appeared over and over again in your presentations are "information" and "teamwork." Our Council of Governors from the start saw the importance of information. That is why CCOHS is in the business it is in. That is why your words will go much further than this room; in the proceedings you will be able to share them. Teamwork is emphasized more and more and you have enlarged the team beyond professionals; you also opened up the idea that professional goes beyond the degree of certification to interest and involvement on a long-term basis.

I don't know whether you had time to look at where occupational safety and health services fit into the health care system and whether they can or should be integrated into the health care system. If you did, we would be interested to hear your views.

Jim Ogilvie

Our group looked at whether occupational safety and health services should be integrated into the health care system. We could not reach a consensus, but there seemed to be strong opinion that the WCB should not be part of the health care system. Cross-communication is clearly needed. We felt that occupational safety and health services need a coordinated effort that recognizes that the labour environment and health care are distinct from each other. Occupational health and safety needs a consensus-building basis and this mechanism is a political mechanism as opposed to a professional mechanism. The inevitable conclusion was that politics and health care perhaps don't mix that well at the decision-making level. One idea was that community medicine under the Ministry of Health might be a more appropriate approach to total health where you can coordinate both on and off the job health and safety services. Our last comment was that union clinicians and company doctors are probably less credible than community physicians.

Peter Stopford

We didn't deal with this issue, but I would like to impart something we are doing at Bruce Nuclear Generating Station. Some of the training we have put on recently for our employees they've taken home. I was contacted by a lady who was putting on a seminar for homemakers in the area, most of whom are the wives of our workers. They are concerned about some of the substances they have found in going through the cupboards at home. They have asked us to put on a session for them on the hazards of the various chemicals that are there. With the help of our occupational health and safety nurses, we will be doing that in January.

Jack Richman

Before we could say what the changes in the services and activities are, we wanted to define them. We came up with the REC principle (Recognition, Evaluation, Control) in occupational hygiene, medicine and safety on the hygiene side of the hazards in the

workplace, physical and chemical. On the medical side of health there is the recognition of health, disease and health surveillance. On the safety side there is recognition of the mechanical and ergonomic hazards. Having looked at those, we also found some common areas in services and activities--workplace assessments, joint health and safety committee activity, WHMIS activity, education, risk management, claims management, and how to manage absenteeism.

As to where it fits into the health care system, we could come to no decision. We felt that for now, it should be left to evolve naturally.

We listed the legislation: WHMIS, Occupational Health and Safety Acts of the provinces, Workers' Compensation Acts, Transportation of Dangerous Goods Acts, Hazardous Products Acts, Health Disciplines Acts governing the medical and nursing professions, Human Rights, and so on. Then we looked at the impacts of this legislation on the changing role of professionals. We felt it forced government, labour and business to integrate toward common activities and goals. It provided for the worker's "right to know," education, training and resources. It dealt with confidentiality and how medical information is handled. We looked at the Quebec model and its pros and cons and felt that, at the present time, it has failed in what it was trying to do.

We determined as very important the legislation that brought about the Canadian Centre for Occupational Health and Safety. Its service of information helps education and training and is a marvelous result of what has happened and is bringing about change.

The advantages are cooperation, joint training, common goals, better and quicker response to concerns by government and by professionals, improved worker and management understanding and awareness, decrease in fatalities, and long term cost benefits.

One disadvantage initially is the cost, because we all have jobs we would not otherwise have which are costly to the companies and unions and people who employ us. All of us believe that cost should not be a concern when it comes to health and safety, but nevertheless cost could be considered an initial disadvantage. A major disadvantage that we are concerned about is that because of the activity, a number of unqualified people have been getting into the act, which has created some poor advice and direction of activities in a non-productive way. If employers fail to get the right advice and see that health and safety has not given them the benefit they need, they might turn their backs on health and safety in general.

<u>Lillian Vine</u>

We have heard some opposite points of view on where occupational health and safety does or should fit into the health care system.

One of the things that didn't come up in discussion was the stresses on occupational health professionals of the rights for workers that the legislation was bringing about. It sounds as though professionals have adapted and the stresses are not serious. This may be part of the evolving cooperative role of the professionals that you all talked about.

PLENARY REPORTS OF LABOUR, MANAGEMENT AND PROFESSIONALS

* A Changing Role?
* A Model and Procedures

CCOHS/CCHST

Lillian Vine

We do not distribute evaluation sheets; I don't much care for them. Not because we don't want to hear your criticisms and your compliments. We do want your comments, positive or not, because they help us to improve; I assure you we take them very seriously. I like to judge how well the workshop is going by how hard it is to get you from your groups or coffee breaks back into the plenary session. If it is difficult because you are all engaged in lively discussion, I know that the workshop has been a success. By that standard, this is a very successful workshop indeed.

This session is the reporting of the homogeneous groups. The first day you were in mixed groups; today you were divided into homogeneous groups of labour, management and professionals. Now you are going to report on how your group has reacted to what you brought back from all of the workshops you were in yesterday, its conclusions and recommendations.

REPORT OF LABOUR

Julian Kloda - CAW Health and Safety Representative

This is a brief summary of the Labour group's conclusions.

We agree with the concept of total cooperation between labour and management; we have to strive for the same goal, which is a safe environment for all workers.

We disagree with medical surveillance because it infringes the right to privacy of workers.

We agree that all health and safety professionals should be officially trained and certified, and that this should be subject to continual upgrading.

We agree that there must be impartiality of health professionals on health and safety committees; they should be engaged for consulting purposes only.

In summation we recognize the role of health and safety professionals as a constantly changing one, and feel we must work together to achieve one goal of a safe, secure work environment for all workers.

REPORT OF MANAGEMENT

Jack Richman

Many of us did not feel comfortable with the separation from the groups we were originally with; these groups were working well and there was a process going on; when

that was brought to an end it made some of us feel isolated. One person felt that the separation was probably a good thing and we should see if we could feel together as we did during the workshops. The test will be the different reports.

It is nice to see that we agree with the report from labour on such things as professionalism, certification, and common goals. We too felt it was important to continue to work together. We talked about well-being. We couldn't come up with a common body of thought, but we think we may be able to have a common code of ethics. That is that each of the individual professional bodies have a code of ethics which would be brought together into a common code of ethics to be used as a guideline for all the professionals.

We feel we need common forms, common training modules, common professional development modules with more focus on safety and ergonomic issues. Health has become a major thing, but safety at the workplace has never received the attention that it deserves. The main costs, the main injuries, and the main problems are still in safety.

We talked about the struggle for credibility of the occupational health and safety field among peers, among professionals, among management, among labour.

Professionals cannot be part of the joint health and safety committee, because by legislation they have to be either on the side of labour or management. But we think health and safety committees should be tripartite--the workers, management, and health and safety personnel. A joint health and safety committee should be forced by legislation to have joint training or joint seminars and workshops for common goals and common interests. It was also felt that no one--either on the side of management or on the side of labour--should sit on a joint health and safety committee coming straight from the floor or straight out of a supervisory role without initial training. Training, not only about health and safety, but also about the goals, philosophy and code of ethics. This is one way we can eliminate the adversarial situation.

The last issue has to do with the attitude of professionals and labour. If we wait until people are in the workforce to teach them about health and safety, we are starting too late. It should be taught in the public schools and universities. Students taking courses in engineering or marketing or business administration should take health and safety as part of the curriculum so that when they enter the workforce as engineers, managers, and such, health and safety is always part of the whole picture. It should always be in their minds so that it becomes part of the normal process in the running of a business.

Lillian Vine

Thank you very much. When and how you teach occupational health and safety is something that has come up in many of our workshops. It is a message participants want heard by all the educational authorities.

REPORT OF PROFESSIONALS

Bill Kennedy - Ontario Ministry of Labour

The biggest challenge at this workshop was defining an "occupational health and safety professional." Some who have worked in the field for a long time felt that they were professionals even though they had no formal training. Others felt that training is what makes a professional.

Part of the problem is that occupational health and safety is in a transition period. It is actually a new area with new concerns. Because there was not enough personnel available in the past to fill occupational safety and health positions, some of us fell into these roles by default and developed in them.

Our consensus on the definition of an "occupational health and safety professional" is a person who meets four criteria:

1. has advanced education;
2. uses intellectual skills;
3. belongs to a self-governing organization which hands out accreditation and requires advancement of vocation; and
4. observes a code of ethics.

Besides recognizing health and safety professionals by the four criteria, we said that there was a need to entrench the concept of the occupational health and safety professional in the legislation.

We then looked at the traditional role of occupational health and safety professionals. We came up with two models of occupational health and safety service delivery. In the past these were:

1. clinical medicine with diagnosis and treatment (called the clinical model); and
2. the safety model.

The mode of operation of both models was basically reactive. Their developing role is different. The mode of operation has changed from reactive to proactive. Occupational health and safety has also changed from being safety oriented to being health oriented. One result is that many different professions are now needed in occupational health and safety.

We recommend that the occupational health and safety professional be used as a resource person on the shop floor. We also think it is important that professionals get together and have an organization or voice to express what they believe are the concerns and the solutions to occupational health and safety problems.

Where do these professionals and their services fit into the health care system? One place is as part of the general public health care system--Quebec is the only province that has attempted this to date, but it is rumoured that this experiment has failed. Another option is to have a separate delivery model for occupational health services. Our consensus was that, if this was done, it should be done under the Ministries of Labour rather than the Ministries of Health.

QUESTIONS AND DISCUSSION

Lillian Vine

I would like to ask the panel how they react to the professionals' definitions and models and recommendations where they are the providers and you are the users.

Jack Richman

I would concur that we need a definition and the one developed by the professionals sounds like a reasonable one. It coincided with what we said in the management group. But, if you don't have the people to provide the service, definition does not make much difference. Legislating this definition would eliminate those who fell into occupational health and safety positions by default (which might be the purpose), but unless the education and training systems are in place, we would not have enough "professionals" to fill the positions. We should have it as a goal, but I am reluctant to say it should be legislated.

Julian Kloda

Speaking for the Labour group, health and safety is such a wide field when you speak of professionals. Personally, I don't consider myself a "professional" in documentation. but when it comes to working in a plant and knowing the Bills and legislation, I am a professional as far as the workers go. But I cannot be called a professional health and safety representative--for that there would have to be training and certification. It has got to be there.

J A Callaghan

In the curriculum of the education system, the whole question should be introduced far before the university level in my opinion because the conditioning may be a little late. It has been done in Grade 12 in some places; I would like to see that even at Grade 7 or 8 before people's minds are fixed.

Jim Ogilvie - Imperial Oil

The Occupational Hygiene Association of Ontario recognizes that there is a need for getting the word out sooner. It has been getting in touch with guidance counsellors at the secondary school level and putting forward a package for training and telling the students about the career opportunities available in occupational health and safety.

Tom Murphy - Canadian Society of Safety Engineering

The Canadian Society of Safety Engineering has already taken on the endeavour of educating people on occupational health and safety at an early stage. We have been working on a project initiated in the United States called "Project Minerva." It is just in its infancy stage; we have just completed an introductory brochure which we will be

distributing to all the occupational health and safety interests. It is a developed program that goes into the high schools, technical colleges and universities.

Terry Ryan - Professional

There is not enough coordination and there is far too much fragmentation in every area of occupational health and safety. We can look around here today and find documentation on any subject--you can get information from the Workers' Compensation Board of BC; the Canada Safety Council publishes information; the IAPA (Industrial Accident Prevention Association) in Ontario publishes information; the Canadian Society of Safety Engineering offers courses; Occupational Health Nursing may have the same thing. I think we are going to have to come together as Canadians and make some political decisions about our roles. And why would the Canada Safety Council have anything to do with occupational health and safety? I think it is a bit ridiculous to have all this duplication if the federal government is associated with the Canadian Centre for Occupational Health and Safety. Why should the taxpayers' money go to any other group when there is already a group functioning quite well? I get the impression that everyone wants to get into this and grab a piece of the pie. If a service is offered by an organization, why should we not all take advantage of it?

Jack Richman

I think the Canadian Centre for Occupational Health and Safety has done a very good job. It has, for one, created controversy. It creates awareness. It also pulls people together to meet and discuss issues; without CCOHS we wouldn't be meeting today ourselves. We don't always have to agree on everything, but the Canadian Centre for Occupational Health and Safety is responsible for giving us the opportunity to express our opinions and perhaps reach agreements. I agree that it is difficult to coordinate everyone's efforts, but maybe CCOHS would take on another role which is to coordinate the pieces of the pie. Fragmentation always happens when a profession is growing. This is a normal progression but it would be wrong to stop progressing.

Bill Kennedy

In occupational health and safety, I don't think we are being saturated with information. We aren't getting down to the small businesses. Health and safety hasn't been raised as a big political concern; there is not a major public concern over worker health and safety. Why isn't there a hue and cry over workers dying in the workplace, whereas, when it comes to environmental poisons in very low amounts slowly leaking into the Great Lakes, this gets us all really worried. I think it's good that all these people and organizations are making all these efforts. Coordinating them may be a little premature. A lot of them are serving special constituents and there isn't a lot of duplication or overlapping.

J A Callaghan

The very fact that this group, representing various segments of society, has met here is a step in the right direction. Fifteen or twenty years ago this would have been unheard

of. It is important to address the problem jointly, because I don't step outside the cloud of acid rain any more than my manager does; it falls on all of us. What is poisoning him is poisoning me. What we have to do, and CCOHS is to be congratulated for doing it, is break down those traditional barriers between the groups for the common interest. If you can pull in other interested groups to make the effort greater, that is to be commended, too.

Peter Stopford

I agree that we need greater education. Certain larger companies, mine included, are going into the schools with various introductory courses. There is a very large--60%--component of working people right across Canada and more in the United States that have no representation in a workshop like this. Who speaks for those unorganized individuals in the small companies? They do not have the expertise or the support of organizations like unions. Maybe this is something CCOHS should address.

Lillian Vine

This has been a great concern of our Council of Governors; they have looked at the issue over a period of time. There are indeed a lot of people working in small businesses who don't know how to get the information. Our Council concluded that it is unrealistic to expect to reach them on a one-on-one basis. We are serving a very large country with a relatively small staff and a relatively small budget. But we can reach them through intermediaries. One of the experiments is through franchisers, such as Canadian Tire. There are trade associations that some of them belong to and we need their help. But one-on-one, we are not going to be any more successful than anyone else has been. Much as we would like to be able to do it, we need help.

Some degree of duplication is probably unavoidable in a country that has 13 jurisdictions in occupational health and safety. We try to avoid duplication. People tell us we are filling a void. We very much favour working collaboratively. There is an item on all the agendas of our Council and Executive Board and Senior Management meetings called "Collaboration"; it is a standing item that comes up three times a year on Council, six times a year on Executive Board and weekly on Senior Management. We are always looking at ways of working with other people.

Jack Richman

Our clinics at the Industrial Doctor get publications from CCOHS that are passed out to our clients of whom 95% are small industries. The difficulty has been budgeting; CCOHS can no longer distribute several copies of publications for each worker so s/he gets only one copy. Hopefully, that one copy is taken back and copied and given to the other people in the company. It is important to get the information out.

Vic Barker

I would like to make a comment on something that came up in our group this morning, but which hasn't been discussed here. That is power. Professionals don't have much power in

Canada. The feeling is that because we are so fragmented and because this is a multidisciplinary area, we have a situation where we cannot, even in individual groups such as occupational hygienists, form a consensus opinion. We therefore cannot influence government, labour or industry as a profession. Perhaps the professions need to get together to amplify our individual strengths as an occupational health and safety profession. In this way we would have some power to influence the direction in which occupational health and safety will grow and to influence the legislation that is driving occupational health and safety today.

Lillian Vine

The words that would sum up this workshop would be "cooperation," "definition," and "information." Cooperation came up very early in the discussions in relation to management and labour working together with the professionals as partners or as a resource.

The definition issue is one which took all of you a very long time. I expect it was a lot harder than you originally thought it was going to be. You came up with a definition which is fine because you all accept it.

There was some talk about information, both the duplication of it and the lack of it. That is one of the contradictions that we at CCOHS live with. There may be too much information, but people call us and tell us they are starved for knowledge. Just talking about some of the effects of WHMIS--some of the questions that came to us were absolute cries for help from people who didn't know where to begin.

You talked about a changing role from reacting to accidents and illnesses to being proactive and preventing them. In your groups you probably talked about the demand because as professionals you are providers. If people want to be treated, you will treat them. If people want to know what it is that is going to make them ill or has made them ill and how they can prevent it, you will do that. Proactive means acting before treatment is needed, but you want to be prepared for the demand. For that you need information and cooperation and definitions.

The comment I need to take into consideration is the feeling of isolation you mentioned when we put you into homogeneous groups. Having heard your reports, I am not 100% convinced that you didn't really want that opportunity to be in your own group. Do you feel now that something came from being separated?

Jack Richman

For the first few minutes we felt uneasy. But as the group got going, people from similar but varying backgrounds started to blend again.

Julian Kloda

I feel it was good to meet with a homogeneous group because we had representation from each of the Workgroups, and when we put everything down on paper we found each group had much the same ideas. Each workgroup was working towards the same goals.

Bill Kennedy

I agree. I think it's very smart on the part of CCOHS to work on our behavioural patterns for a consensus by putting us into mixed groups. When we finally got back together to report on our individual constituencies, we found that we compare. I think it is very important that there be some identity given to the workshop reports. When the proceedings come out, people are going to see quickly that there were some differences and what they were. That's what we can work on to bring ourselves closer together on those differences.

Tony Hammer

To most corporations, occupational health and safety professionals have the same status as the internal auditing department. The very viability of the enterprise depends on giving information to them which they will handle and have them take the responsibilities. The challenge for us is to get around this. There are two ways--the first is that we are fragmented and we are not making a concerted effort to get together with a unified voice. This would address the issue of where occupational health and safety professionals report within the organization, kicking out the notion of involving superannuated cart-horses from production to go into pasture before retirement to be employed in this area. It is very difficult for professionals to be on joint health and safety committees. The reason is that the Ministry of Labour tends to think in adversarial terms and has to set up health and safety committees. The truth is that many joint health and safety committees are extremely successful and get on very well together. But we need an avenue and support from the Ministry of Labour for professionals to be represented and not polarized by the preconceptions of the Ministry of Labour about the things that go on in that arena. It would be constructive for CCOHS, which has a track record in this area, to make representations to the Ministry of Labour on this issue.

Nicholas Siksay - Stelco Steel

That is an issue that did come up. We saw ourselves in a Department of Labour framework which is contractual and adversarial and almost by definition confrontational, rather than as we hoped we would be seen as professionals in a scientific forum offering both management and labour the best possible scenario that the facts and studies might allow. That was one of the thrusts that we talked about. One wonders when you deliver occupational health care under a Department of Labour mantle, whether by definition you offer it to the highest, squeakiest, loudest bidder. This has led to the kind of polarization Tony has spoken of. It should be a strong comment from the professionals at this meeting, that we are not labour and we are not management. We see ourselves as offering a special skill as adviser and counsellor.

Bill Kennedy

Professionals have a tendency not to want to get bloodied in conflict. Unfortunately, this is where we have lost our credibility. People talk about conflict as being negative. Linda Jolley has said that conflict is necessary and organized labour will

always use conflict as its necessary mode of operation. It uses it in a constructive sense for what it wants to achieve. There is nothing wrong with that. In occupational health and safety, we all have different viewpoints, but the end result is that we all want a healthier and safer workplace. There are different ways to achieve that and we want to find the best way. The best way is to talk about it and talking about things always leads to differences in opinion. I would like to use the word "conflict" in a pleasant not a negative connotation--a way to be constructive and talk about things. I don't think we can do away with it--it's a way to discuss. That is the way we operate in a democratic society.

Lillian Vine

Thank you all for an excellent workshop. I remind you that your comments will be most welcome and that we do take them very seriously. We will produce a proceedings from this workshop. We transcribe and edit the tapes; that draft is reviewed by the speakers and the chairmen of the workgroups. Within three months, these proceedings will be published and sent to each participant of the workshop.

We have approval from the American Board of Industrial Hygiene to award certification maintenance credits for this workshop. We have also just heard from the Occupational Medical Association of Canada that it will accredit our workshops if we send our agendas for approval. If there are other professional organizations you would like us to approach, we would be glad to do so.

It has been marvelous having you with us and listening to your lively discussions. You have made challenges to CCOHS and you have made challenges to yourselves; you need to take those challenges back to the people you work with.

Your words will spread far beyond the confines of this room. As Jack has said, it is costing us more each year to put words on paper; therefore we now charge everyone but participants for the proceedings of our workshops. That is sad because it could reduce the number of people who will read your words, but we do encourage people to copy our publications and distribute them.

I look forward to meeting with you at another CCOHS workshop.

WORKSHOP PARTICIPANTS

James Alexander
Manager, Loss Control
Quebec & Ontario Paper Co Ltd

Carolee Bailey
President
Health Telecom Associates Inc

Larry Ball
Specialist, Accident Prevention
General Electric Canada

Victor A Barker
President
Occugiene International Inc

Bill Bell
Plant Safety Supervisor
3M Canada

Elisabeth Brown
Personnel Assistant
Leaver Mushroom Company Ltd

J A Callaghan
National Vice President
Canadian Brotherhood of Railway,
Transport and General Workers

Jim Carney
Safety & Security Officer
Workers' Compensation Board

Ron Carrier, Representative
United Steelworkers of America
Local 5762

Carol-Lynn Chambers
Occupational Health & Safety
Officer
Lambton County Board of Education

Charles Emberson
Acting Health & Safety Chairperson
United Steelworkers of America
Local 1005

Andrew Rae Erskine
Safety and Loss Manager
Lever Brothers Ltd

Eva Fenczyn-Kip
Staff Development Coordinator
Brock University

Peter Fletcher
Executive Manager
Canadian Society of Safety
Engineering

Stewart Franck
Assistant Health & Safety Officer
Peel Board of Education

Sue Freshwater
Safety Coordinator, Clinic Labs
Chedoke-McMaster Hospital

Susan Gordon, OHN
Vice President of Operations
Employeecare Limited

Norma Graham
Executive Assistant
Medical Walk-In Clinic Inc

Carla Graveney
Occupational Health Nurse
Galco Food Products Ltd

Michael Guindon, Representative
United Steelworkers of America
Local 5762

Dr Tony Hammer
Medical Director
Polysar Limited

Lorna Hendrickson
Policy Analyst
Manitoba Environment & Workplace
Safety and Health

John Horgan, Coordinator
Occupational Health & Safety
Municipality of Metropolitan
Toronto

Bill Kennedy
Planning Analyst
Ontario Ministry of Labour

Julian Kloda
CAW Health & Safety Representative
3M Canada

Lee Lewis, MD
Director, Safety Hygiene &
Environmental Systems
Canada Post Corporation

Jan Logan
Director of Occupational Hygiene
and Safety
Northern Telecom

Kenneth R Morrell
Safety Coordinator
IBM

Jill Marzetti, Coordinator
Health and Safety Clinics
Ontario Federation of Labour

Sharon Matthias, Executive
Director, Management Support
Services
Alberta Health

Susan Meurer
Occupational Health Educator
Parkdale Community Health Centre

Alison Milne
Registration & Safety Specialist
Ciba-Geigy Canada Ltd

Murray Miner
Vice President
Associated Loss Prevention
Services Inc

Thomas J Murphy, President
Canadian Society of Safety
Engineering

Edna Newcombe
Occupational Health Nurse
Kellogg Canada

Ray Nicholson, MD
Kraft Limited

Jim Ogilvie
Industrial Hygienist
Imperial Oil Limited

Judith Pope, President
Ontario Occupational Health Nurses
Association

David Poulin
Occupational Health Physician
Dow Chemical Canada Inc

Jack Richman, MD
Industrial Doctor
Medical Walk-In Clinic Inc

Terry Ryan
Manager, Loss Prevention
Canadian Tire Corporation

Alex Safronsky
Industrial Hygienist
Goodfellow Consultants Inc

George Salovaara
OHS Coordinator
North Bay Psychiatric Hospital

Nicholas Siksay, MD
Medical Department
Stelco Steel

Peter Stopford
Safety Officer/Radiation
Coordinator
Ontario Hydro